DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/24/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		185289 B. WING _		IG		05/1	05/15/2012
NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK				2	REET ADDRESS, CITY, STATE, ZIP CODE 1200 STONY BROOK DR LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON SHOULD BE COM HE APPROPRIATE	
F 000	INITIAL COMMENTS An abbreviated healt #18355 was initiated	th survey investigating KY and concluded on 05/15/12. In Care unsubstantiated the		000	DEFICIENCY)		
LADODATORY	DIDECTORIO CO DOCUMENTO	CURRILER DERRECENTATIVES CONTAINED			TITLE		(Xe) DATE
LADUKATUKY	DIVECTOR 9 OK LKONIDEK/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 100645